Senate Bill 542

By: Senators Hill of the 32nd, Harp of the 29th and Smith of the 52nd

AS PASSED SENATE

A BILL TO BE ENTITLED

AN ACT

To amend Chapter 36 of Title 31 of the Official Code of Georgia Annotated, relating to durable power of attorney for health care, so as to amend the signature requirement; to provide for related matters; to provide for applicability; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 36 of Title 31 of the Official Code of Georgia Annotated, relating to durable power of attorney for health care, is amended by striking subsection (a) of Code Section 31-36-5, relating to execution of agency and limitation on agents, and inserting in lieu thereof the following:

"(a) A health care agency shall be in writing and signed by the principal or by some other person in the principal's presence and by the principal's express direction. A health care agency shall be attested and subscribed in the presence of the principal by two or more competent witnesses who are at least 18 years of age. ~~In addition, if at the time a health care agency is executed the principal is a patient in a hospital or skilled nursing facility, the health care agency shall also be attested and subscribed in the presence of the principal by the principal's attending physician.~~ A durable power of attorney for health care shall have no force or effect if the declarant is a patient in a hospital or skilled nursing facility at the time the durable power of attorney for health care is executed unless the durable power of attorney for health care is signed in the presence of two witnesses as provided in this Code section at least one of whom is a member of the professional clinical staff or a social services worker designated by the chief of staff and the hospital administrator, if witnessed in a hospital, or the medical director, any physician on the medical staff who is not participating in the care of the patient, or a social services worker, if witnessed in a skilled nursing facility."

SECTION 2.

Said chapter is further amended by striking subsection (a) of Code Section 31-36-10, relating to the form for the power of attorney for health care and authorized powers, and inserting in lieu thereof the following:

"(a) The statutory health care power of attorney form contained in this subsection may be used to grant an agent powers with respect to the principal's own health care; but the statutory health care power is not intended to be exclusive or to cover delegation of a parent's power to control the health care of a minor child, and no provision of this chapter shall be construed to bar use by the principal of any other or different form of power of attorney for health care that complies with Code Section 31-36-5. If a different form of power of attorney for health care is used, it may contain any or all of the provisions set forth or referred to in the following form. When a power of attorney in substantially the following form is used, and notice substantially similar to that contained in the form below has been provided to the patient, it shall have the same meaning and effect as prescribed in this chapter. Substantially similar forms may include forms from other states. The statutory health care power may be included in or combined with any other form of power of attorney governing property or other matters:

'GEORGIA STATUTORY SHORT FORM
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

NOTICE: THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (YOUR AGENT) BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU, INCLUDING POWER TO REQUIRE, CONSENT TO, OR WITHDRAW ANY TYPE OF PERSONAL CARE OR MEDICAL TREATMENT FOR ANY PHYSICAL OR MENTAL CONDITION AND TO ADMIT YOU TO OR DISCHARGE YOU FROM ANY HOSPITAL, HOME, OR OTHER INSTITUTION; BUT NOT INCLUDING PSYCHOSURGERY, STERILIZATION, OR INVOLUNTARY HOSPITALIZATION OR TREATMENT COVERED BY TITLE 37 OF THE OFFICIAL CODE OF GEORGIA ANNOTATED. THIS FORM DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWERS; BUT, WHEN A POWER IS EXERCISED, YOUR AGENT WILL HAVE TO USE DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS FORM. A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS THE AGENT IS NOT ACTING PROPERLY. YOU MAY NAME COAGENTS AND SUCCESSOR AGENTS UNDER THIS FORM, BUT YOU MAY NOT NAME A

HEALTH CARE PROVIDER WHO MAY BE DIRECTLY OR INDIRECTLY INVOLVED IN RENDERING HEALTH CARE TO YOU UNDER THIS POWER. UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THIS POWER IN THE MANNER PROVIDED BELOW OR UNTIL YOU REVOKE THIS POWER OR A COURT ACTING ON YOUR BEHALF TERMINATES IT, YOUR AGENT MAY EXERCISE THE POWERS GIVEN IN THIS POWER THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME DISABLED, INCAPACITATED, OR INCOMPETENT. THE POWERS YOU GIVE YOUR AGENT, YOUR RIGHT TO REVOKE THOSE POWERS, AND THE PENALTIES FOR VIOLATING THE LAW ARE EXPLAINED MORE FULLY IN CODE SECTIONS 31-36-6, 31-36-9, AND 31-36-10 OF THE GEORGIA "DURABLE POWER OF ATTORNEY FOR HEALTH CARE ACT" OF WHICH THIS FORM IS A PART (SEE THE BACK OF THIS FORM). THAT ACT EXPRESSLY PERMITS THE USE OF ANY DIFFERENT FORM OF POWER OF ATTORNEY YOU MAY DESIRE. IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

DURABLE POWER OF ATTORNEY made this _____ day of _____, ____.

1. I, _____

(insert name and address of principal)

hereby appoint _____

(insert name and address of agent)

as my attorney in fact (my agent) to act for me and in my name in any way I could act in person to make any and all decisions for me concerning my personal care, medical treatment, hospitalization, and health care and to require, withhold, or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to make a disposition of any part or all of my body for medical purposes, authorize an autopsy of my body, and direct the disposition of my remains.

THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISION YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH CARE, INCLUDING WITHDRAWAL OF NOURISHMENT AND FLUIDS AND OTHER LIFE-SUSTAINING OR DEATH-DELAYING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES. IF YOU WISH TO LIMIT THE SCOPE OF YOUR

AGENT´S POWERS OR PRESCRIBE SPECIAL RULES TO LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY, OR DISPOSE OF REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS.

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations (here you may include any specific limitations you deem appropriate, such as your own definition of when life-sustaining or death-delaying measures should be withheld; a direction to continue nourishment and fluids or other life-sustaining or death-delaying treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electroconvulsive therapy, or amputation):

_____

_____

_____

THE SUBJECT OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT IS OF PARTICULAR IMPORTANCE. FOR YOUR CONVENIENCE IN DEALING WITH THAT SUBJECT, SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT ARE SET FORTH BELOW. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INITIAL THAT STATEMENT, BUT DO NOT INITIAL MORE THAN ONE:

I do not want my life to be prolonged nor do I want life-sustaining or death-delaying treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining or death-delaying treatment.

Initialed _____

I want my life to be prolonged and I want life-sustaining or death-delaying treatment to be provided or continued unless I am in a coma, including a persistent vegetative state, which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered such an irreversible coma, I want life-sustaining or death-delaying treatment to be withheld or discontinued.

Initialed _____

I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery, or the cost of the procedures.

Initialed _____

THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU AT ANY TIME AND IN ANY MANNER WHILE YOU ARE ABLE TO DO SO. IN THE ABSENCE OF AN AMENDMENT OR REVOCATION, THE AUTHORITY GRANTED IN THIS POWER OF ATTORNEY WILL BECOME EFFECTIVE AT THE TIME THIS POWER IS SIGNED AND WILL CONTINUE UNTIL YOUR DEATH AND WILL CONTINUE BEYOND YOUR DEATH IF ANATOMICAL GIFT, AUTOPSY, OR DISPOSITION OF REMAINS IS AUTHORIZED, UNLESS A LIMITATION ON THE BEGINNING DATE OR DURATION IS MADE BY INITIALING AND COMPLETING EITHER OR BOTH OF THE FOLLOWING:

3. ( ) This power of attorney shall become effective on _____ (insert a future date or event during your lifetime, such as court determination of your disability, incapacity, or incompetency, when you want this power to first take effect).

4. ( ) This power of attorney shall terminate on _____ (insert a future date or event, such as court determination of your disability, incapacity, or incompetency, when you want this power to terminate prior to your death).

IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAMES AND ADDRESSES OF SUCH SUCCESSORS IN THE FOLLOWING PARAGRAPH:

5. If any agent named by me shall die, become legally disabled, incapacitated, or incompetent, or resign, refuse to act, or be unavailable, I name the following (each to act successively in the order named) as successors to such agent:

_____

_____

IF YOU WISH TO NAME A GUARDIAN OF YOUR PERSON IN THE EVENT A COURT DECIDES THAT ONE SHOULD BE APPOINTED, YOU MAY, BUT ARE NOT REQUIRED TO, DO SO BY INSERTING THE NAME OF SUCH GUARDIAN IN THE FOLLOWING PARAGRAPH. THE COURT WILL APPOINT THE PERSON NOMINATED BY YOU IF THE COURT FINDS THAT SUCH APPOINTMENT WILL SERVE YOUR BEST INTERESTS AND WELFARE. YOU MAY, BUT ARE NOT REQUIRED TO, NOMINATE AS YOUR GUARDIAN THE SAME PERSON NAMED IN THIS FORM AS YOUR AGENT.

6. If a guardian of my person is to be appointed, I nominate the following to serve as such guardian:

_____

(insert name and address of nominated guardian of the person)

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signed _____

(Principal)

The principal has had an opportunity to read the above form and has signed the above form in our presence. We, the undersigned, each being over 18 years of age, witness the principal´s signature at the request and in the presence of the principal, and in the presence of each other, on the day and year above set out.

Witnesses:	Addresses:
_____	_____
	_____
_____	_____
	_____

Additional witness required when health care agency is signed in a hospital or skilled nursing facility.

I hereby witness this health care agency and attest that I believe the principal to be of sound mind and to have made this health care agency willingly and voluntarily.

Witness:_____

~~Attending Physician~~

Member of the professional clinic staff or social services worker designated by the chief of staff and the hospital administrator, if witnessed in a hospital, or the medical director, any physician on the medical staff who is not participating in care of the patient, or social services worker, if witnessed in a skilled nursing facility.

~~Address:~~ _____

_____

YOU MAY, BUT ARE NOT REQUIRED TO, REQUEST YOUR AGENT AND SUCCESSOR AGENTS TO PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, YOU MUST COMPLETE THE CERTIFICATION OPPOSITE THE SIGNATURES OF THE AGENTS.

Specimen signatures of agent and successor(s)	I certify that the signature of my agent and successor(s) is correct.
_____	_____
(Agent)	(Principal)
_____	_____
(Successor agent)	(Principal)
_____	_____
(Successor agent)	(Principal)"

SECTION 3.

This Act does not in any way affect or invalidate any health care agency executed or any act of any agent prior to July 1, 2006.

SECTION 4.

All laws and parts of laws in conflict with this Act are repealed.